Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

AGING AND DISABILITY SERVICES ADMINISTRATION
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
NURSING ASSISTANT TRAINING PROGRAM
PO BOX 45600
OLYMPIA WA 98504-5600

DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION
PO BOX 47864
OLYMPIA WA 98504-7864

Washington State Department of Health

APPLICATION FOR NURSING ASSISTANT BRANCH LOCATION TRAINING PROGRAM APPROVAL (NATCEP)

DATE OF APPLICATION

NAME OF BRANCH TRAINING LOCATION			TELEPHONE NUMBER (INCLUDE AREA CODE)	
STREET ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRESS
MAILING ADDRESS IF DIFFERENT FROM STREET ADDRESS	CITY		STATE	ZIP CODE
LEGAL NAME OF SPONSORING HEALTH CARE FACILITY, HOSPITAL, SCHOOL OR OTHER ENTITY			TELEPHONE NUMBER (INCLUDE AREA CODE)	
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE
STREET ADDRESS IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE ZIP CODE		E-MAIL ADDRESS
NAME OF PROGRAM DIRECTOR, NURSING ASSISTANT TRAINING PROGRAM			CONTACT TELEPHONE NUMBER (INCLUDE AREA CODE	

If facility was approved for Nursing Assistant Training previously, what is your training program approval number?

Describe the classroom space allotted to your training program. Specify type of room, square footage, self-contained or shared space, room equipment and classroom furniture, square footage, maximum number of students that can be comfortably accommodated, other uses of this room during non-class time and the availability/location of teaching materials and audio-visual equipment. Attach a separate sheet if necessary. Is this classroom off-site, that is, located elsewhere from the street address listed above? ☐ Yes ☐ No

Describe the training laboratory and the personal care equipment used for the practice of clinical skills. Attach a separate sheet if necessary.

Will the student go off-site for any clinical training? ☐ Yes ☐ No If yes, list the name(s) of these clinical training sites.

List the teaching resources for the program. For example, name and publication date of textbooks and audio-visual equipment.

Textbooks:

Audio-visuals:

Other (specify):

Number of hours proposed for your Nursing Assistant Training Program: Classroom _____ Clinical _____ Total Hours: _____

NOTE: Please submit the following forms for Program Director and staff instructor (classroom and clinical) involved in this training: 1) DSHS 14-370, 2) DSHS 09-961 and 3) DSHS 14-371.